DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155061	B. WING		05/16/2011
NAME OF E	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TO THIS OF T	KO VIDEK OK SOI I EIEK		l l	LBY ROAD	
WOODL	AND HILLS CARE C	CENTER	LAWRE	NCEBURG, IN47025	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This wisit was for	n the Investigation of	F0000	Submission of this plan of	
		r the Investigation of	F0000	correction does not constitut	ie l
	Complaint IN000	J90462		admission or agreement by t	• • • • • • • • • • • • • • • • • • •
	C 1. i (D.100)	200462 Handadida 1		provider of the truth of facts	
	-	090462- Unsubstantiated		alleged or correction set fort	l l
	due to lack of evi	idence.		the statement of deficiencies This plan of correction is	··
	11 1 1 1 1 7 7	1		prepared and submitted bec	ause
	Unrelated deficie	ency is cited.		of requirement under state a	l l
				federal law. Please accept t	
	Survey dates: May 11, 12, and 16, 2011.			plan of correction as our cre- allegation of compliance. Ple	• • • • • • • • • • • • • • • • • • •
				find enclosed the plan of	,430
	Facility number:			correction for the survey end	ling
	Provider number			May 16th, 2011.Due to low s	cope
	AIM number: 10	00274510		and severity of the survey	
				findings, please also find enclosed sufficient	
	Survey team:			documentation providing	
	Penny Marlatt, R	N, TC		evidence of compliance with	the
	Diana Sidell, RN			plan of correction. The	
	Janie Faulkner, R	RN (May 12, 2011)		documentation serves to cor the facility's allegation of	ıtırm
				compliance. Thus, the facilit	ty
	Census bed type:			respectfully requests the gra	
	SNF: 10			of paper compliance. Should	d
	SNF/NF: 51			additional information be necessary to confirm said	
	Total: 61			compliance, feel free to cont	act
				me.	
	Census payor typ	oe:			
	Medicare: 11				
	Medicaid: 43				
	Other: 7				
	Total: 61				
	Sample: 3				
	Supplemental sar	mple: 2			
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AOXJ11

Facility ID:

000022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			ETED	
		155061	B. WING			05/16/2	011
	PROVIDER OR SUPPLIER		40	3 BIEL	DDRESS, CITY, STATE, ZIP CODE BY ROAD ICEBURG, IN47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	·	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREI	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	cited in accordan	reflects state findings ace with 410 IAC 16.2 or completed on May ev Faulkner, RN					
F0514 SS=D	each resident in an professional stand complete; accurate accessible; and sy The clinical record information to identhe resident's asseand services provi	naintain clinical records on ecordance with accepted lards and practices that are ely documented; readily estematically organized. I must contain sufficient natify the resident; a record of essments; the plan of care ided; the results of any eening conducted by the ess notes.				•	
		record review,	F0514		F514 Requires the facility to maintain clinical records on e resident in accordance with		06/01/2011
		,			accepted professional standa and practices that are comple		
	interview,	the facility			accurately documented; read	lily	
	failed to e	nsure			assessable; and systematica organized. The facility will ens	sure	
	medicatio	n orders were			this requirement is met through the following corrective	_	
	accurately	transcribed on			measures:1. Resident C was harmed. The respiratory		
	recapitula	tion orders and		treatment order was the physician and th			
	as needed	oxygen was	treatment was discontinued. The resident upon review at this time		ime		
	document	ed when used.			was not wearing oxygen and order was being followed.2. residents have the potential t	ÁII	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND LAN	or course now	155061	A. BUII B. WIN	LDING		05/16/2011
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
WOODL	AND HILLS CARE C	CENTER		1	NCEBURG, IN47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	This affected 1 of 3			affected. All re-capitulation orders will be reviewed to ensure	sure	
	residents reviewed for				accuracy.3. The policy and procedure for transcribing	
	complete	and accurate			rewrites and continuous oxyg were reviewed with no chang	jes
	records in	a sample of 3.			made. (See attachment A ar B). Nursing staff were inserv	riced
	(Resident	#C)			on the above procedure. The DON or her designee will utile	ize
	Findings i	nclude:	DON or her designee will utilize the nursing monitoring tool (See attachment C) to ensure all new orders as well as the monthly rewrites are transcribed accurately on the physician's telephone order, MAR/TAR, and the rewrites. If an error is noted,			new / s and
	A policy a	policy and procedure			the order will be clarified with	·
	for "END	OF MONTH			physician immediately and transcribed correctly. The DON or her designee will also daily monitor all residents who have an	
	PHYSICI.	AN'S ORDER				/e an
	REVIEW	PROCEDURE			oxygen order to ensure that i oxygen is in use, that it is sig	ned
	(RE-WRI	TES)" was			out on the respiratory TAR. physician's orders and oxyge useage for residents will be	
	provided l	by the			reviewed daily times four we then weekly times four week	
	Corporate	Nurse			then every two weeks times months, then quarterly therea	
	Consultan	t on 5/16/11 at			 The audits will be reviewed during the facility's quarterly 	ed
	11:47 a.m	. The policy			quality assurance meetings a the plan of action will be adju	
	included,	but was not			accordingly. 5. The above corrective measures will be	
	limited to:	: "PURPOSE:	completed on or before June 2011.		1,	
	To ensure	that all new				

000022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	OI COMMENTON	155061	A. BUI B. WIN			05/16/2011
NAME OF F	PROVIDER OR SUPPLIER		P. 1111	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
WOODLA	AND HILLS CARE (CENTER		1	ELBY ROAD ENCEBURG, IN47025	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	orders, ch	anged orders				
	and discor	ntinued orders				
	are correc	tly reflected on				
	physician	order rewrites.				
	PROCED	URE: 1.				
	Compare	new rewrite				
	with previous rewrite					
	and with a	all additional				
	orders wri	itten since last				
	rewrite sig	gned by				
	physician.	2. Add any				
	new order	rs to the new				
	rewrite5	6. Compare				
	MAR (Me	edication				
	Administr	ration Record)				
	for new m	onth with new				
	month's re	eviewed				
	rewrites.	Make				
	correction	s, additions,				
	etc. 6. Co	ompare				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		INSTRUCTION 00	(X3) DATE COMPL		
	155061		B. WIN	G		05/16/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ELBY ROAD		
WOODLA	AND HILLS CARE C	CENTER		1	NCEBURG, IN47025		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Treatment	sheet for new					
	month wit	th new month's					
	reviewed	rewrites"					
	1. Reside	nt #C's record					
	was review	wed on 5/12/11					
	at 5:43 p.m. The record						
	indicated	Resident #C					
	was admit	ted with					
	diagnoses	that included,					
	but were r	not limited to,					
	bronchitis	, chronic					
	obstructiv	e pulmonary					
	disease, ar	nxiety, and					
	depression	1.					
	An annual	l Minimum					
	Data Set A	Assessment,					
	dated 2/16	5/11, indicated					
		C received					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155061		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/16/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ELBY ROAD ENCEBURG, IN47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	oxygen therapy in the				
	last 14 day	ys.			
	Physician's recapitular dated May indicated a respiratory. Albuterol in 0.5 mill dose vial to with Atroval solution 2 via a nebutimes a date.	tion orders, 2011, an order for y treatments of 2.5 milligrams liliters in a unit to be given yent 0.2% .5 milliliters lizer four y for chronic e pulmonary			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155061		A. BUI	LDING	onstruction 00	(X3) DATE COMPL	ETED
		10001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/10/2	011
	PROVIDER OR SUPPLIER			403 BIE	ELBY ROAD		
	AND HILLS CARE C				NCEBURG, IN47025		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Records for	or April and					
	May 2011	failed to					
		ne 8:00 p.m.					
	dose of the	e Albuterol and					
	Atrovent l	nad been					
	administer	red.					
	During an interview on						
	5/12/11 at	8:40 p.m., the					
	Corporate	Nurse					
	Consultan	t indicated					
	staff had c	clarified the					
	order for t	the 8:00 p.m.					
	respirator	y treatment and					
	the treatm	ent was					
	supposed	to have been					
	discontinu	ied, but					
	showed up	the next					
	month's re	ecapitulation					
	orders. The	he Director of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/16/2	LETED
			STREET A	LBY ROAD		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
Nurses (D	O.O.N.)					
provided a	a copy of the					
original or	rder, dated					
2/10/11, v	with the order					
to discont	inue the 8:00					
p.m. respi	ratory					
treatment. The D.O.N.						
provided a	a copy of the					
clarificati	on order, dated					
5/12/11 at	8:15 p.m., to					
discontinu	ie the 8:00 p.m.					
nebulizer	treatment.					
During an	interview on					
5/16/11 at	11:45 a.m.,					
the D.O.N	I. indicated					
they usual	lly don't have					
any proble	ems with the					
re-writes,	they had					
changed t	he way they					
	PROVIDER OR SUPPLIER AND HILLS CARE OF SUMMARY'S (EACH DEFICIEN REGULATORY OR Nurses (Deprovided a original of 2/10/11, which disconting p.m. respirit treatment. provided a clarification of 5/12/11 at discontinum nebulizer During an 5/16/11 at the D.O.Nethey usual any problem.	of correction Identification number: 155061 PROVIDER OR SUPPLIER AND HILLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Nurses (D.O.N.) provided a copy of the original order, dated 2/10/11, with the order to discontinue the 8:00 p.m. respiratory	IDENTIFICATION NUMBER: 155061 RECOVIDER OR SUPPLIER AND HILLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Nurses (D.O.N.) provided a copy of the original order, dated 2/10/11, with the order to discontinue the 8:00 p.m. respiratory treatment. The D.O.N. provided a copy of the clarification order, dated 5/12/11 at 8:15 p.m., to discontinue the 8:00 p.m. nebulizer treatment. During an interview on 5/16/11 at 11:45 a.m., the D.O.N. indicated they usually don't have any problems with the re-writes, they had	IDENTIFICATION NUMBER: 155061 ROVIDER OR SUPPLIER AND HILLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Nurses (D.O.N.) provided a copy of the original order, dated 2/10/11, with the order to discontinue the 8:00 p.m. respiratory treatment. The D.O.N. provided a copy of the clarification order, dated 5/12/11 at 8:15 p.m., to discontinue the 8:00 p.m. nebulizer treatment. During an interview on 5/16/11 at 11:45 a.m., the D.O.N. indicated they usually don't have any problems with the re-writes, they had	DEPTIFICATION NUMBER: 155061 ABUILDING B WING B WING	DENTIFICATION NUMBER: 155061 R WING R

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061			LDING	NSTRUCTION 00	(X3) DATE COMPL	LETED
	PROVIDER OR SUPPLIER			STREET A	IDDRESS, CITY, STATE, ZIP CODE ILBY ROAD NCEBURG, IN47025	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	did the re-	writes, but					
	now are g	oing back to					
	the old wa	y. She said					
	they origin	nally had one					
	person do	all the					
	re-writes a	and then they					
	went to every floor						
	doing thei	r own, and					
	now "are	going back to					
	one perso	n doing them."					
	2. A polic	ev and					
	procedure	•					
	"CONTIN						
		THERAPY"					
		ded by the					
	Minimum	•					
		or on 5/12/11					
		n. The policy					

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		(X2) MU A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 05/16/2	ETED
	PROVIDER OR SUPPLIER		D. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ELBY ROAD ENCEBURG, IN47025	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	included,	but was not					
	limited to:	: "16.					
	Document	t initiation of					
	therapy in	residents					
	medical re	ecord,					
	including:	a. Data and					
	time of set upg.						
	Signature	and credentials					
	of personr	nel					
	administer	ring oxygen"					
	Resident #	#C's record					
	indicated	an order for					
	oxygen at	2 liters per					
	minute pe	r nasal cannula					
	as needed	with 0.9%					
	normal sa	line for					
	humidific	ation for					
	shortness	of breath.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED	
		155061	B. WIN			05/16/2	011
NAME OF I	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
WOODL	AND HILLS CARE O	CENTER		LAWRE	NCEBURG, IN47025		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	On 5/12/1	1 at 6:55 p.m.,					
	Resident #	#C was					
	observed :	sitting in a					
	wheelchai	r with her					
	oxygen or	at 2 liters via					
	nasal canr	nula. Resident					
	#C indicated she uses her						
	oxygen "a	ll the time."					
	Review of	f the following					
	nurse's no	tes indicated					
	Resident #	C was using					
	oxygen:						
	- 5/8/11 at	: 12:00 a.m					
	oxygen or	n at 2 liters via					
	nasal canr	ıula.					
	- 5/9/11 at	: 12:30 p.m					
	oxygen or	at 2 liters via					
	nasal canr	nula.					
	- 5/11/11 a	at 12:00 a.m					

T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/16/2	ETED	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY ROAD					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
oxygen on at 2 liters via							
nasal cannula.							
- 5/12/11 at 12:00 a.m							
oxygen on at 2 liters via							
nasal cannula.							
Review of the							
Respiratory Flow							
Records for April and							
May 2011 failed to							
indicate Resident #C had							
been using oxygen, as all							
the grids for initials of							
staff administering the							
oxygen had been left							
blank.							
3.1-45(a)(2)						
3.1-50(a)(1)						
	Review of Respirator Records for May 2011 indicate R been using the grids f staff adminoxygen hablank.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Oxygen on at 2 liters via nasal cannula. - 5/12/11 at 12:00 a.m oxygen on at 2 liters via nasal cannula. Review of the Respiratory Flow Records for April and May 2011 failed to indicate Resident #C had been using oxygen, as all the grids for initials of staff administering the oxygen had been left	ROVIDER OR SUPPLIER AND HILLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Oxygen on at 2 liters via nasal cannula. - 5/12/11 at 12:00 a.m oxygen on at 2 liters via nasal cannula. Review of the Respiratory Flow Records for April and May 2011 failed to indicate Resident #C had been using oxygen, as all the grids for initials of staff administering the oxygen had been left blank. 3.1-45(a)(2)	DEF CORRECTION DENTIFICATION NUMBER: 155061 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Oxygen on at 2 liters via nasal cannula. - 5/12/11 at 12:00 a.m oxygen on at 2 liters via nasal cannula. Review of the Respiratory Flow Records for April and May 2011 failed to indicate Resident #C had been using oxygen, as all the grids for initials of staff administering the oxygen had been left blank. 3.1-45(a)(2)	DEFORECTION DENTIFICATION NUMBER: 155061 A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 403 BILLBY ROAD LAWRENCEBURG, IN47025 LAWRENCEBURG, IN47025 LAWRENCEBURG, IN47025 DESCRIPTION SHOULD BE PERCEINCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX TAG DESCRIPTION SHOULD BE PERCEINCY APPROPRIATE TO CHOSE SHEET BURNER OF CORRECTION SHOULD BE CHOSES SHEET BURNER OF CORRECTION SHOULD BE CHOSES SHEET BURNER OF CHARGE OF CORRECTION SHOULD BE CHOSES SHEET BURNER OF CHARGE OF CHARGE OF CORRECTION SHOULD BE CHOSES SHEET BURNER OF CORRECT	DEPOTRECTION DENTIFICATION NUMBER: 155061 A BUILDING NUMBER: 155061 BUILDING N	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED /2011		
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY ROAD LAWRENCEBURG, IN47025					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		